KANSAS CERTIFICATE OF IMMUNIZATIONS - FORM B

MEDICAL EXEMPTION

Student Name:_____ Birthdate:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Parent/Guardian:_____

Telephone: _____

Medical exemption due to _____
for the following vaccine(s):

☐ DTP/DTaP ☐ MMR

☐ Pertussis Only ☐ Rubella Only

☐ IPV ☐ Other:_____

I certify the physical condition of this child to be such that the inoculation(s) specified on this form would seriously endanger the life or health of this child.

Signature:_____ Date:_____

Name (print):_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Telephone: _____

Medical License Number:_____ State of Licensure:_____

A Medical Doctor (M.D.) Or Doctor of Osteopathy (D.O.) Must complete this affidavit. Annual medical exemptions shall be documented on this form and attached to the student's Kansas Certificate of Immunization (KCI). Annual medical exemptions shall be completed as long as the medical exemption is warranted.

KANSAS IMMUNIZATION PROGRAM
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